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ABSTRACT

A number of Maryland institutes have inaugurated an associate professional continuum, or latticework in mental health. The programs are designedly generalist in character, aiming at the preparation of persons competent to work in a variety of clinical settings. Job assignments and degree of clinical responsibility reflect many factors, level of training, prior background, and experience. The associate professional enter the mental health field taking on beginning professional responsibilities under close supervision. The associate professional can either continue his education in shifts or level off in satisfying professional roles of his own choice. This program permits the individualization of training to suit the human and professional needs of personnel. Mental health facilities also benefit through the availability of a continuum of manpower appropriate to the various levels of care and administrative responsibility. (Author/KJ)

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Manpower for Community Health: *the Associate Professional Concept*

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A number of Maryland institutions, individually and in consort, have in recent years inaugurated an *associate professional* continuum, or *latticework*, in mental health. Graduates have been variously called mental health technicians, mental health associates, counselors, even psychiatric technicians; their education runs the gamut from one year certificate programs analogous to licensed practical nurse curricula to two year associate in arts degree programs in the public community colleges, a four year B.S. offering at Morgan State College (1970-71), and on to post-baccalaureate training in psychotherapy at the Phipps Clinic. To a considerable degree these several programs articulate with each other and with an hierarchy of matching job classifications in the public mental health facilities of Maryland.[3]

The programs are designedly generalist in character, aiming at the preparation of persons competent to work in a variety of clinical settings. Field instruction sites and, currently, employing institutions range from public schools to community mental health centers, child day care facilities, half-way houses, psychiatric hospitals, adolescent centers, and geriatric institutions, just to name a few. Job assignments and degree of clinical responsibility have reflected many factors: level of academic training, personal interests and maturity, prior background in the human services, experience acquired while on the job, and the nature of the institution itself.

Details of curriculum design and the interdigitation of curricula, one with another, and with evolving programs for continuing education of the associate professionals have been described at length elsewhere.[2,4,7,8,11] Suffice it to note here that the community college curricula are eclectic in content, drawing upon the basic biological sciences -- a semester of nursing anatomy and physiology is included, for example -- as well as heavy doses of the social sciences and general education. The clinical courses emphasize a collage of interpersonal, intrapsychic, sociologic, and group process material woven together by carefully integrated campus and practicum

learning experiences. It is the faculty's intention that students will learn about people by interacting with people -- with their own peers, with patients, faculty, colleagues in the other disciplines -- and, at intervals, by standing back to examine their role in the interpersonal process. Students learn to make use of their own feelings in the understanding of behavior and, finally, to habitually interpret feelings and phenomena from a point inside the pertinent value system.

Little stress is placed on the mastery of specific tasks or institutional routines, as such. Their education is conspicuously functional. Among the more critical pedagogical issues are: learning to observe behavior, how to interview people, social organization, the implications of helplessness, how people adapt, and why; the subtlities of intervening constructively, the expectation of human growth. Once employed following graduation, the associate professionals translate these broad principles into the specifics of action appropriate to the institutional milieu where they work.

In the Department of Mental Hygiene's facilities associate degree persons receive a starting salary of $6459, with six annual increments to a maximum of $8487. Promotion to supervisory, teaching, or specialized clinical roles will, however, probably include salaries in the $6975 to $9165 range, while completion of the baccalaureate programs should result in a boost to the $8,500-$11,000 range. Higher grades are contemplated for selected individuals as they develop over the years in the work situation. In Maryland's four participating community colleges more than 200 students, of diverse ethnic, socio-economic, and life experience backgrounds, are enrolled (1969-70) in the mental health curricula; numerically, this is more than the combined total of students currently enrolled in all Maryland graduate curricula in the traditional human behavior fields (ie. psychiatric nursing, clinical psychology, psychiatric residents, etc.). Nationally, where just four years ago less than a half-dozen experimental programs were underway, today there are some twenty-five colleges with operational programs (1969-70) and another 20-30 getting ready for the 1970-71 academic

year.[6] By 1975 conservative estimates would suggest an hundred or more colleges will be offering mental health worker curricula at the associate degree and baccalaureate levels.

In Maryland, despite the obstacles and resistence to be expected upon the interposition of a new species of professionals in the midst of time-worn institutions, these programs have been eminently successful. *Why?* It is not suggested that the associate professionals are privy to any new, unique psychiatric tool; they lay claim to no new or special theory of human behavior. To the contrary, they are taught, and practice at the beginning *professional* level, the traditional proven approaches common to the other mental health professions. What then have been the societal and institutional forces undergirding their successes? *And, relatedly, are these curricula and their graduates really different; if so, in what way?*

Let us examine each of these questions in turn. In actuality, they are a very different 'breed o' cat' compared with most contemporary mental health professionals, but not in terms of their professional capabilities, not vis-a-vis their clinical roles at the interface of practitioner with community, family, or patients. *What is different is their unorthodox ROUTE to professional competence.* They enter the mental health field after two, sometimes four years of academic preparation, taking on *beginning* professional responsibilities under close supervision as the *first step of a continuing process of career development aiming at eventual mastery of their field.* That is, their initial community college studies, far from being an educational terminus, is starting point on an articulated educational design incorporating the sequential alternation of advanced studies in juxtaposition with periods of full-time employment in professional roles of increasing responsibility, roles reflecting both an individual's intrinsic skills and his progressively expanding academic base. Not that everyone would (or could) follow along the same stereotyped pattern of continuing education, or move at the same rate. People are all different and the associate professional *concept* potentiates individual self-realization on the premise that so long as

associate professionals have free access to advanced educational input, then they will take advantage of it when ready. Meanwhile, associate professionals would 'level off' for varying periods in satisfying professional roles -- and that without stigma. Personnel would invest in the next educational step [for them] only when they felt it personally advantageous, at a time when they had come to know themselves and were acquainted with the spectrum of roles available in their discipline. Employment at the intermediate professional levels would not be demeaning, nor would the associate professionals become 'locked-out' of the established system of institutional advancement merely because they had not *yet* completed full professional training.

Graduate associates would subscribe only to those advanced courses or curriculum *units* as were directly useful to their own professional goals. These, in turn, could be predicated upon the individual's real-life experiences in the mental health field. Nor would associate professionals have to start from scratch academically in order to move vertically or laterally. Previous credits would count towards higher degrees, eliminating the kind of academic *hang-up* facing today's diploma nurse seeking baccalaureate training, who finds she must repeat the nursing courses along with the general education requirements.

The virtue of a system of articulated educational *units -- the associate professional concept* -- is in its versatility. It permits the individuation of training to suit the human and professional needs of personnel. Family circumstances, past liabilities, second choices need not block advancement; nor would differences of personal temper and maturation have any longer to be corseted in a single educational mold. One's training and professional role becomes free to evolve on a *real time* basis in response to changing times and developing sense of professional purpose. Similarly, mental health facilities benefit through the availability of a continuum of manpower appropriate to the various levels of care and administrative responsibility natural to a broad community outreach effort. Manpower becomes more adaptable, capable of flowing readily into areas of shortage or newly opened professional horizons.

Thus evolving patterns of mental health care, say within a comprehensive care matrix, would catalyze the building of parallel continuing education units specific to the critical issues of the new field, curriculum units whose very implementation would bespeak the timeliness of their academic content. This means professional education which fast becomes up-to-date and stays up-to-date.

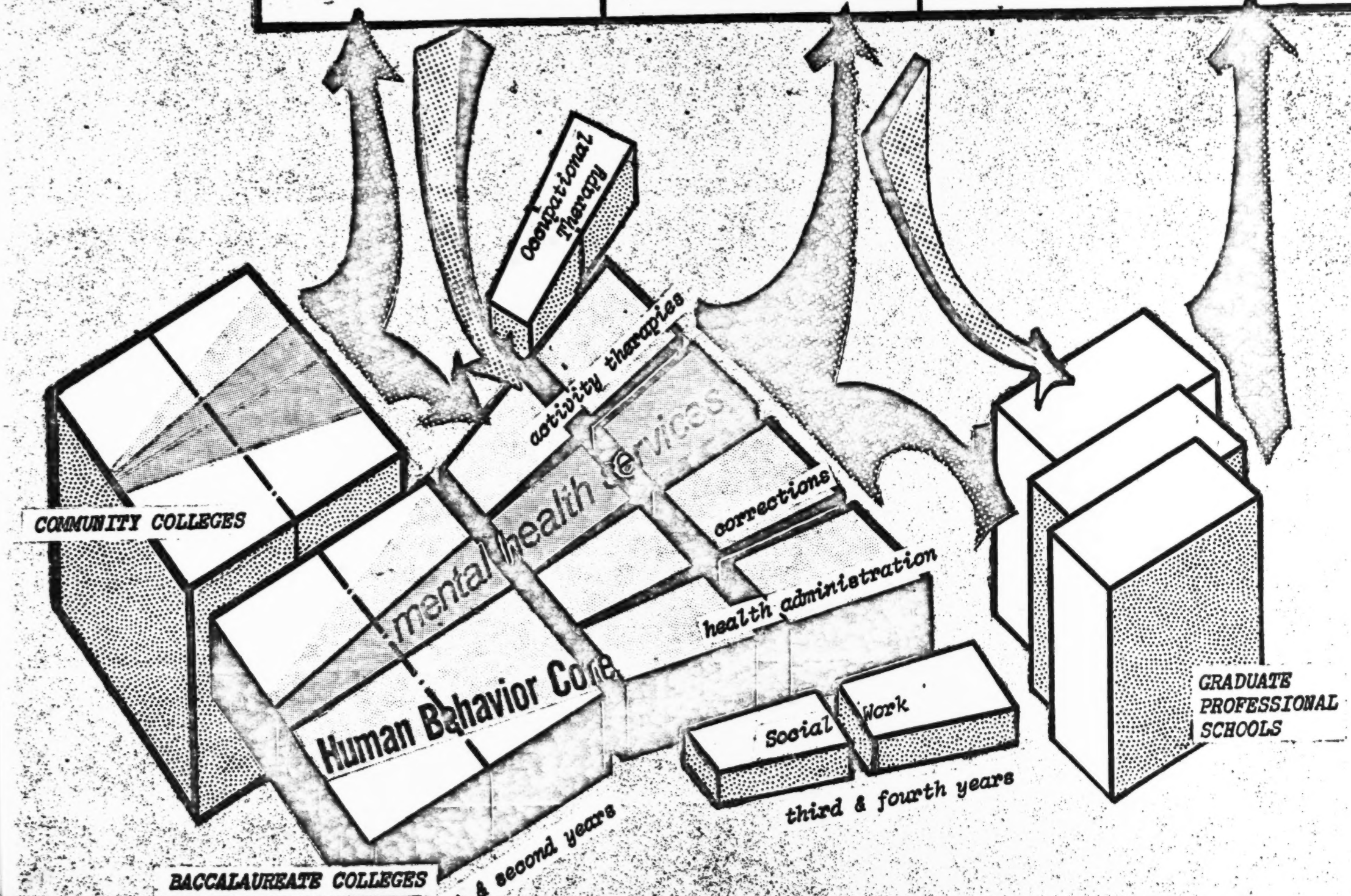
DEVELOPING A MENTAL HEALTH CAREER LATTICE

By carefully delineating discrete educational *packages* or modular curriculum units of one to two year's length, and having sequential relationship to each other, the *inter-college* transfer of academic credits becomes a practical reality. The architectural concept of *modularity* is equally applicable to curriculum building; the problem in education, as also in architecture, is to sufficiently reduce the size of the basic module so as to maximize flexibility (and efficiency) without, at the same time, destroying the essential integrity of the unit as a viable unit. Traditional four-year baccalaureate programs are too lengthy to permit a modular approach; but also our existing hodge-podge of inservice offerings are too small and inconstant. Once a network of subspecialty limbs branching from a central academic trunk [core] is made operational, health personnel are free to move laterally between institutions and related mental health fields; vertically via promotion or through higher education. (See Fig. 1.)

Realistic training, practical training commensurate with an individual's *actual* clinical responsibilities is facilitated, while variations in response to particular needs of the community (or proximal institutions) can be judiciously included without undermining the overall educational schema. In that sense it makes feasible efficient, economic professional education *à la carte*. Associate professionals achieve solid preparation in the broad range of human behavior during their entry-level and intermediate academic sequences, then add in depth and specialized expertise in subsequent units *which have been chosen expressly because of their relevance to the individual's ongoing work and long range professional goals and interests*. Just because one specializes only when it is directly pertinent to one's career goals, the total

Mental Health Series Career Lattice

MENTAL HEALTH SERVICE FACILITIES		
MENTAL HEALTH ASSOCIATES (Technicians)	MENTAL HEALTH SPECIALISTS	HUMAN BEHAVIOR PROFESSIONALS



R.M. Vidaver '69

amount of professional education, as measured in years or semester credits, might often be reduced without in any way compromising the professional's knowledgeability. In sharp contrast, today's typical graduate student, moving uninterruptedly from high school through college, masters, and doctorate programs, becomes frequently entrapped into earlier and often premature specialization. Precocious concentration on narrow-focused research necessitates mastery of considerable related theory much of which may be quite tangential to the mainstream of the field or the student's ultimate professional interests. The problem is not specialization in research or clinical work, per se, but rather when one ought to specialize. Too often the youthful graduate student becomes scooped up into ever narrowing educational parameters before he has gained any first hand knowledge of the overall field or his own *identity* in it. Intermittent full-time employment as *bona fide* member of the mental health team sandwiched between educational modules would eliminate this difficulty.

What about new manpower resources? The associate professional *concept* offers four signal advantages. Namely: [1] With the formulation of attractive open-ended *careers* from a community college base, it becomes possible to recruit from that vast army of many-talented persons who as young adults never jumped on the higher education bandwagon (prerequisites to admission are merely high school or equivalency); [2] Going to work and going to college cease to be mutually exclusive, a vital matter for poor people and those with family responsibilities. By interspersing remunerative employment within a comprehensive matrix of higher education, the beginning associate professional can support himself without sacrifice to long range professional objectives or loss of educational continuity; [3] Middle class youngsters would have the option of financial independence, the chance to free themselves from dependence upon an endless string of parental allowances, scholarships, and part-time jobs; and, relatedly, [4] Brief, one to two year educational units, balanced by truly well paying jobs, would permit more realistic tuition charges, tuition more in keeping with the actual high cost of allied health professions education (particularly since their employers may

well carry some, or all, of the tuition burden for their *own* personnel).

This latter point may seem picayune; after all what's a thousand dollars more or less in tuition payments to a medical school operating on a $20,000 per year, per student budget? Just that; health careers education is mighty expensive and our undergraduate colleges are traditionally budgeted on the basis of low-cost general education curricula. Over the next decade as community and state colleges generate the bulk of beginning health personnel serious financial inequities can be expected. Adequate tuition charges may well mean the difference between quality curricula -- *acceptable to graduate schools and the mental health centers* -- versus cheaper, but unacceptable programs.

A last point. Once upon a time women entering the health occupations did not marry. Today they not only get married, but have babies as well; and all of this seems to be taking place in the very years they *ought* to be in graduate school. Segmentalized *associate professional* education facilitates the combination of family and career in the mental health fields. Much the same could be said about the problems of military service for men. An undergraduate curriculum in mental health would allow for military service in a mental health role.

WHAT'S BEEN HOLDING US BACK?

The associate professional *concept* promises more and better manpower. If this is not merely a matter of semantics, then why has the new era been so long delayed? The health fields have traditionally functioned through the work of two disparite classes of health personnel; the professional and the so-called "*non*-professional". To the American public, health services have proverbially meant professional services. Granted, there have always been a flurry of "non-professional" hands busy in the background, but when the average American conceptualized medical care he automatically *targeted in*, mentally, on the Professional.-- the M.D., R.N., or M.S.W. nominally and by law charged with leadership in what has really been *team* health care. Out of the same *un*-reasoning vantage point, the definition of professional grew to be an all-or-

nothing distinction more appropriate to a legal dictionary than the realities of twentieth Century mental health care in urban America. Over generations, common usage has encouraged the elaboration of a cultural *myth*. Thus progressively, by law and by tradition, the licensed physician has come to be responsible for, and obligated to supervise, all other health personnel. Inauguration of such an ethos midway in the 19th Century may have been in the patients' best interests; its effect today, particularly in the public sector, is nothing short of destructive. As things stand now, state hospitals can't hire the needed medical psychiatrists, yet *mustn't* use a substitute. (And much the same interdiction informally exists vis-a-vis psychologists without doctorates and social workers lacking masters training.)

A sufficient number of mental health professionals, trained via the orthodox high school-college-graduate school *express train route*, are not entering our training programs (albeit their absolute number increases slowly). For years now we've maintained a second class citizenry of "non-professionals", untutored and without access to valid career advancement, on the misguided plea that true professionals will be available *"in just a little while longer."* Meantime, the use of poorly trained "non-professionals" has been tolerated as an emergency stop-gap measure. Unfortunately, its been a twenty-five year *emergency*. Isn't it about time we in mental health stopped kidding ourselves, and the general public too?

ENTER THE ASSOCIATE PROFESSIONAL *CONCEPT*

Perhaps our thinking has bogged down in the definition of what it is to be a professional. That is, in the past we have tended to arbitrarily define the term professional along two widely dissimilar (if not contradictory) parameters. Namely: [1] *ACADEMICALLY* -- the professional being that person who has completed a prescribed course of study; and [2] *AS A FUNCTION OF FUTURE POTENTIAL (DEVELOPMENTALLY)* -- hence the professional is that person who by evidence of early scholastic promise seems likely to develop over the length of a career those special attributes we ascribe to the completed professional. (*Complete* meaning many, many years of clinical experience

following the completion of training.) The latter definition, in focusing on the final end-product, ignores the sorry ineptitude of the novitiate professional, the awkward, often bewildered first year resident or psychology intern. It's a practical definition, though, avowing faith in the beginning professional's ability to grow *with the job*, and meanwhile to have the good sense to seek help in those areas beyond his *experience*.

No doubt most individuals with the inner drive to fulfill the academic prerequisites for professional status (in the company of like-motivated classmates) are a good bet to develop the remaining stigmata of *The Professional* over the span of a full career. Much depends on the culture; the identity of the professional is to no little degree sired and sustained by the corporate expectation of family, colleagues, patients, and society in general. But, there is nothing exclusive about the phenomena.

The deep desire to draw knowledge out of one's daily experiences -- *to entertain curiosity, to ask questions, to read, to profit from supervision, to think for oneself* -- are attributes hardly unique to the graduate schooled professional. These are human qualities and stem from a much deeper stuff. Many, no matter the level at which they enter the health professions, are fully capable of maturing under the aegis of solid professional models and strategically timed academic input into qualified *professionals*, in the highest sense.

Graduates of Maryland's associate professional programs are not 'weak sisters' academically. Their education, if limited in amount, is qualitatively superior. They may lack experiential breadth, but they do possess the basic academic tools by which to grow professionally. They know how to use the professional literature and how to utilize professional supervision (on an interdisciplinary basis). They have learned how to use, and depend on, their own initiative. As with the beginning professional, their value as practitioners is in their potential for the future. Initially they are prepared for uncomplicated professional duties delegated to them under close supervision. But such begs the real question, which might well be this: *What are to*

be the skills and breadth of judgement of these selfsame associate professionals after five, ten, twenty years of clinical experience, along with a congruent input of supervision, advanced education, and responsibilities of progressively increasing moment.

We are confident that many, if not most will by then have achieved full professional competence; and those remaining within the mental health field will have gravitated into meaningful, if less demanding roles. Some, of course, who enter from community college programs won't mature one iota and others so minimally as hardly recompense society for the cost of their education. So be it! No one in Maryland intended that the mental health series would become a free ride, carrying every new associate uninterruptedly downstream to the professional sea. Suffice it that those willing enough and strong shall no longer be blocked from swimming upstream to the limits of their capabilities.

Our state mental institutions need not continue strapped in the old manpower bind, unable to secure adequate professional staffing, yet enjoined from developing suitable job classifications and personnel to fill such jobs at the beginning and intermediate professional levels. In the past, asylum guards tended to be persons forced by circumstances to accept the low-pay, low-status menial jobs offered by our public institutions. With few exceptions they were not representative of the average American young person, nor the average ghetto dweller, not a typical mature housewife either. If the state hospital attendant pool was to be the only manpower resource upon which to found a precedent-shattering corps of middle professionals, few state institutions could hope for success. The pity of it all. Lacking anything in the way of meaningful intermediate careers, comparable for example, to elementary school teaching, public mental institutions could never hope to corral average Americans into entry-level jobs. With no future attached, who'd want 'em.

Without open-ended, real careers appealing to the typical young *Joe* or *Jane*,

there was no way to attract that multitude of young people intent on going to college, nowadays, yet who do not aspire to graduate school. Two million students are currently enrolled, full time, in the nation's junior (community) colleges; another million more part time and well over two million in baccalaureate colleges. Most junior college students do not go on to the doctorate. They go to work. Within the United States, the baccalaureate degree (and more recently, the associate in arts degree, too) have been the standard tickets of admission into the beginning of innumerable careers in business, teaching, engineering, sales, the mass media, and the civil service. Until the advent of the associate professional curricula, there was no place for them in mental health work. (So they worked in NASA, or land on the moon instead.)

COMMITMENT TO PERSONAL GROWTH

Burgeoning undergraduate curricula for the human services and their promise of large numbers of middle level associate professionals in the imminent future makes this a propitious time for both orthodox mental institutions and the evolving community centers to inaugurate a full spectrum of intermediate professional roles appropriate to the several levels of academic preparation and varying capabilities of the new workers.[5] But that is not enough. Success of the associate professional *concept*, over the long haul, presumes a deep institutional and professional commitment to the philosophy that all health personnel should achieve continued personal and professional growth *within the everyday context of their usual clinical activities*. Ultimate validation of the associate professional movement hinges on the expectation that all health personnel, regardless of *rank*, discipline, level of training or clinical sophistication should continue to strive for new ideas, new techniques, to sharpen their clinical skills and, concommitantly, to teach others what they know. It is a mutual responsibility, a bond between associate professionals and their centers. The associate professionals cannot *make it* on their own. They cannot grow professionally solely out of the vortex of their own mistakes. It is incumbant upon our service facilities *in association with nearby undergraduate colleges* to provide good clinical supervision, sound in-

service seminars and multidisciplinary conferences, and, most importantly, institute a systematic program for advanced collegiate-based professional education, preferably via work-study or similar released time arrangements. Reciprocally, the colleges and professional schools must also move into the institutions and community centers. Regional plans for the coordinated development of associate professional manpower should include collegiate 'extension' services, or comparable satellite educational programs within strategically located clinical facilities. In many instances, state agencies for example, such college level educational operations may be inaugurated under institutional, rather than college auspices. Nonetheless, *these programs should aim(1)to utilize clinical faculty from affiliated professional schools; (2) include additional social and biological sciences; (3) afford college credit applicable to higher degrees; and (4) upon an associate's completion of a full 'unit' or sequence of related courses, qualify him for promotion to the next step educationally and professionally.* Smaller community mental health centers, particularly those decentralized or under indegenous direction might do well to collectively organize curricula on a regional basis, either rotating the site location or using agreed-upon central facilities.

The associate professional programs are not without administrative burden. From the colleges' standpoint, devising non-redundant, articulated academic units and the elimination of extraneous content are major pedagogical challenges; all the more so for the undergraduate colleges since most are little accustomed to allied health professions curricula. At the hospital, clinic and community center level great care must be exercised in the assignment of associate professionals; choosing the right job for the *right* man, at the *proper* phase of his career is critical to their continued professional maturation (not to mention the safety of patients). Amidst the rising hue and cry to humanize our ways of delivering health care it is equally vital that we humanize our personnel policies. Concern for patients and families and interpersonal honesty begins with the demeanor of senior staff in their dealing with subordinates, and so on down the 'line'. Our manner of deploying personnel and helping them to advance

professionally should be individualized with the same sensitivity to human needs we demand in the care of patients.

Other cogent reasons exist for the widespread instigation of associate professional programs: They are able to conserve precious professional manpower by relieving them of innumerable necessary, but uncomplicated *professional* tasks; by freeing up professional time for more demanding clinical and research challenges, and for leadership roles, they can maximize the effectiveness of a limited professional staff; there are powerful economic advantages, too, associate professionals, while capable of handling many professional responsibilities receive but a third to one-half of the professional's salary; undergraduate curricula in the mental health fields can be implemented at a fraction of the cost of additional graduate facilities, while student attrition at the higher academic levels are likely to be much lower -- by then, associate professionals in advanced career levels will 'know' what they want and should 'stick' with the field. It is beyond the scope of this paper to examine such advantages in detail; enterprising and thoughtful observers will have no difficulty in carrying these arguments to their logical conclusion, which for the most part hinge on the specifics of local circumstances, from the availability of nearby collegiate resources to the flexibility of licensing boards and relevant professional societies.[10] One prediction is possible, though. Unless those wanting to initiate the new programs move swiftly to bring together into conjoint action representatives of the four major groups -- higher education, hospitals and clinics state and municipal agencies (including their personnel and fiscal officers), and the professional societies, the chances for real innovation are slim.[9]

The importance of working through in the most painstaking manner the seeming trifles of politics, personalities, and administration cannot be overstated. Still, the validity of the associate professional concept rests on a more metaphysical plane. Let us look further.

While the study of human behavior may be said to encompass the farthest reaches of man himself, the conceptual parameters which customarily define *therapy -- the rightful confines of theraputic intervention and the acceptable in prevention* -- fall within much narrower, close-watched boundaries. Human behaviorists, as *practitioners*, characteristically function inside a field of interpersonal tension, or conflict, operant within individuals or between them (or their institutions). And we are all affected by that conflictual field in part because we are human, in part because we too are constituients of, howevermuch tangentially, a unitary Western complex of rewards, values, and expectations.

We work with people from a human perspective. Our humanity is both chief theraputic tool and grievous impediment to effectiveness. We *cannot but work* with people using observations, understanding, and actions inherently the product of one human machine in communication with, and *simpático* with, that *other* human machine whom we're to "serve".

But what has this to do with a new breed of associate professionals in mental health? Considerable.

Regardless of the particular school of psychiatric thought to which we subscribe, our several therapies evince commonality in their ubiquitous, *a priori* belief that the potential exists, albeit buried, for behavioral change; that the patient, or group, family or community, can draw upon internal resources to develop more rewarding means (or less dangerous, less onerous ones) to resolve conflictual pressures. That is not to discount the importance of outside help to effect change, merely that the majority of individuals -- or societies --can achieve change, and also sustain that change once effected.

We expect -- as a society, as a profession, as individual therapists -- that our patients will *LEARN* new modes of dealing with their internal and exter-

nal environments. *We expect of them personal growth and maturation!*

This may take many forms, from accomodation to a new life-space (such as even a locked word or chemotherapized psyche), to the conquest of neurotic shackles or cultural prejudices or habits of self-destruction, and too, includes growth via more mundane modalities -- school, or the practiced mastery of complex psychomotor skills, as with the musician or athlete. Whether we're psychotherapists working one-to-one, or community activists born of an impoverished ghetto striving to galvanize our soul-fellows to consensual action, we, all of us, presume the capacity for behavioral change in others. *For every action there is an equal an opposite re-action.*

> *HYPOTHESIS: That strong personal expectations of professional (and personal) growth within the mental health worker himself are essential for the establishment of positive change in the patient, family, or community under 'treatment'. Reciprocally, without the realistic probability, and not infrequent occurence of improvement in the therapist's own professional situation, mental health personnel can little succeed in helping others to initiate or sustain new and more sanguine identities.*

What are the manpower consequences? First, although the anticipation of perpetual growth is a natural ingredient of the professional's world, this incentive is neither offered to, nor considered valuable for our army of ancillary and other so-called nonprofessional patient-care personnel. Second, it is suggested here that the tangible, crassly materialistic, narcissistic concerns of professional status, prerogatives, pay, and the general appreciation of one's clinical expertness *are* important; they form the visible proofs of our professional growth. If so, then issues of fees, promotions, academic rank and accolades stand high in the genesis of our professional motivation and effectiveness.

The assistent resident moves up to resident, then chief resident; the instructorto assistent professor; the analytic candidate graduates to analyst; the division chief becomes superintendent; the psychiatric society member is raised to life fellow. Fine, this may all pay dividends in improved patient care. The professional justifiably sees professional growth as a career-long, personally advantageous process

-- *it's very much a part of his scene*. And the rest of the mental health team... Yet whether it's a monolithic custodial institution or a bold inner city outreach effort, the vast preponderence of patient-family-community contact is sustained by persons nominally below the hallowed professional threshold. Within the public sector, because of the dearth of professionals, lower echelon personnel are *de facto* the primary vehicle for community action and patient care.

Patient rehabilitation begins with staff growth. If such be true, then we are obliged to honestly examine the real potential for economic, personal, intellectual, and professional growth possible for "non-professionals" working in our own institution, agency, or community center. *Are we offering the means by which talented, motivated, experienced "non-professionals" can realistically achieve full professional competence, and with it, the recognition and remuneration commonly afforded professionals for the same duties?*

> *More urgently, in facilities without provisions for the upwards evolution of all personnel, is the price of this unconcern paid for out of the lives of patients and their families by way of diminished effectiveness of personnel and programs?*

The dilemma is age-old. With the abolition of the apprenticeship system for health careers education in the late 1800's, the recruit's passage to professional competence became sole responsibility of the university. (And hospital based training separated off from the mainstream of collegiate life, was deemed appropriate for "non-professionals.") Moreover, the public asylums, having neither academic resources nor fertile substrate of attendants ready for training "up" to professional roles, were powerless to help themselves. Chief obstacle was the "non-professionals" woeful lack of secondary school education. In 1950 less than a third of all Americans over 25 had completed high school; even by 1960 the percentage of non-whites possessing a high school degree was a mere 21 percent. State hospitals couldn't teach years of basic adult education; employees were too poor to quit working to go back to school.

That was the way it used to be. Today the associate professional *concept*, combined with sweeping gains in the educational accomplishments of all youngsters, makes

health careers veritably *a spanking new ball game!*

Let's start with the community colleges. Deeply rooted in their local communities, they are a progressive force bridging the gap between the chronic inadequacies of our inner city high schools and the stringent admission demands of the liberal arts colleges. The community colleges come on strong with open admissions, remedial courses, tutors, and counseling. Nor are they hung-up on degrees; many will vigorously push one-year certificate programs (e.g.LPN training) articulated with the associate in arts curricula. They're interested in cooperation with the four year colleges and with their neighboring mental health facilities. What's more, transferability of credits and open-ended curricula *is* their thing. Most are very willing to start associate professional curricula in mental health and the four year colleges are, happily, increasingly motivated to carry the new programs onward. The result: *viable career lattices.* Now add in the active support of state and city mental health agencies and, *voila, JOBS!*

Conjoint alignment of (1) health services, (2) government, (3) education, and, (4) the community permits the concurrent elaboration of new associate professional roles in conformity to newer kinds of health services, along with the concommitant alterations in job classifications, continuing education, and curricula needed to make the career lattice a workable reality.[10]

CAREER LATTICE: FOR THE MANY, OR THE FEW?

Let us face this also, that the first rung of every career ladder should extend well below entry level curricula and, stretching into the farthest corners of the community, seek to capture the imagination of persons *who'd never before dreamed of making-it in a responsible health career.* We are our brother's keeper. That racial prejudice, or poverty, and an emasculated system of secondary education have early frustrated and embittered and scared-off so many minority youngsters is unacceptable excuse to maintain our *professionals only* guild system of allied health education (or its handmaiden, anachronistic admission policies). Contemporary remedial education techniques, counseling, and the growing armamentarium of bright new instructional modalities eliminate any pedagogical rationale for holding entry-level admission standards beyond the

reach of large segments of the community served. Recruitment must be multi-directional; alternative academic pathways to the same entry-level jobs need to be created, each incorporating remedial content pertinent to the specific academic liabilities of that student group.

MULTIPLE POINTS OF ENTRY AND EXIT AT ALL LEVELS

Entry-level curricula must articulate with the community below, with higher education, the mental health facilities, government, and the professions above. Then, as the functional subdivisions of the human services -- community work, child care, drug abuse, geriatrics, etc. -- crystallize out over the 1970's, interdigitating, open-ended career lattices should be developed in each area. Smoothly working, flexible, lattices will be turnkey to the associate professional programs and the validity of the lattices will hinge upon the delineation of multiple points of entry and exit to and from jobs, to and from advanced education. Beginning with access points for the drop outs and under-educated via certificate programs, multiple entry ways should be built into the community college, baccalaureate, and masters programs able to capitalize on past life experiences and earlier academic work, and which contain machinery for qualifying individuals with previous human services work to advanced standing. Housewives, their families grown, mature persons unwilling to stagnate, late-starters unhappy with their first vocational choice, all ought to have a dignified, open-ended means of joining us. *Let people enter the health careers as they are.* Delineate *sequential levels of patient care* appropriate to a continuum of backgrounds, educations, and human talents such that all personnel become utilized to their own maximum capabilities. Provide job opportunities upwards in small increments. Let people go to school as long as it seems immediately valuable to them, then have available the clinical role, job classification, and remuneration appropriate to such an hierarchy of skills and education.

This policy subverts neither professional standards or educational horizons. Nobody gets anything for nothing. Same courses, same practicum experiences (paid or unpaid), same general education subjects as the traditional academic approaches to

professional stature, except that the size of the curriculum units would be smaller.

In summary, two last points. First, today's young people, the world over, are remarkably job sophisticated and adept at separating out from the promises of career opportunities the realities of their own chances. *Careers without free channels for unlimited upward and lateral mobility, NOW, will not attract recruits.* The number of individuals choosing mental health careers (and their ultimate level of academic attainment) is not an accident of fate. It is a predictable phenomena subject to rational manipulation; far higher numbers can be recruited whenever associate professional curricula and intermediate level jobs are readily available. We'll get what we pay for. Lastly, the quality of mental health care would appear to be a direct function of the steady flow of qualified, trained manpower emanating from, *and educated within,* all segments of the community. Only inasmuch as we efficiently utilize manpower derived from all segments, all classes of our population will we become able to meet our mental health service needs. Suburbia and the white middle class might be able to stay afloat for a little longer, but the tide of aged, addicted, delinquent, and estranged swells daily. Adequate mental health care for all America inevitably must require a new approach to education, manpower deployment, and career advancement.[1] The associate professional *concept* offers one alternative to this end.

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